The 'Ayah' and the Elderly: Illness, Nursing and Intimate Labour in Kolkata's Domestic Spaces

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Introduction

A WHO (World Health Organization) report mentions about the category of super-agers referring to people in the age group of 70 to 80 and those who possess the mental and physical capacity of their decade-younger counterparts. With trend of rapid global population ageing, it is predicted that by 2030, 34 nations across the globe are set to witness 20% of the population above 65 years. In 2015, WHO coined the term "healthy ageing" with the aim to achieve health and well-being of older adults, and sustain an environment conducive to healthy ageing. The Pew Research Center (2015) found that India is the largest source of international migrants largely comprising of young adults. The 2020 Longitudinal Ageing Study in India reports that around 26% people above the age of 60 either live alone or with their spouse (Benjamin Plackett, 2022). A demographic transition is predicted with 320 million of the population being above 60 by 2050 (ibid). According to a report published in 'Entrepreneurs' (Rangroo and Mehta, 2021), the eldercare business part of the unorganized sector in India is quite lucrative and predicted to rise to $5 billion.

This study has been conceptualised through an everyday, rigorous observation of my late maternal uncle who was in home-care for 3.5 years due to cerebrovascular attack and later succumbed to cardiac arrest on 4th December 2018. His caregiving needs were outsourced to two ayahs distributed over the night and day shifts; the shifting dynamics of intimacy and care

negotiations as caring labour was doled out to the ayahs constituted my entry point into the sphere of home-care for the elderlies by the ayah care service. The purpose of the study is to examine the illness narratives emerging from the paid caregivers (locally known as the ayahs) and family caregivers to understand ageing, chronic illness and caring for the elderlies.

Research design

Probability purposive sampling and snowballing has been utilized for the study. At the initial stage of designing the research, it was decided that ayahs would be approached through the ayah care centers. However, with the covid-19 onset many ayah centers were shut down that created the posed serious constraint in sample design. Secondly the few ayah centers, I could reach out to refused to allow ayahs to talk with me apprehending that I would provide them employment. This insecurity of the ayah care centers indicates the precarity of ayah care centers as they are contingent on the commissions earned through the ayahs that range from 30 INR a day to 60 INR a day. In return, they allocate ayahs according to their experience and hands-on knowledge of the patients. The alternative approach was to reach out to ayahs through the personal networks of referring them as interlocutors like peers, colleagues, personal networks and domestic workers. The latter approach turned out in the favour of the research as I could investigate the multiple modes of entries of ayahs in this home-care unit. In-depth face-to-face and telephonic interview was conducted with the 30 ayahs in either the home-setting of the family, the ayah or the interlocutor based on the convenience of the ayahs and the time of interview. **16 family case studies** have been conducted to unravel and expound on the interconnection between ageing bodies, illness and caring practises adopted by the family members or family caregivers through outsourcing of carework in the form of ayah care service for older adults to analyse and reflect on the themes of caring paradigm, caring practises and sharing/distribution/dissemination of carework for older adults in home-care settings. Given the ethical predicaments involved in interviewing patients with chronic illness or in EOL stage, I steered away from conducting any interview with them, instead I engaged in a conversation enquiring about the condition of the patients who were in a position to talk. Semi-structured interview schedule with a detailed interview guide was prepared prior to conducting the interviews. The questions were merged together while asking so that the respondents do not feel overwhelmed with the barrage of questions considering the probing required stoking memories of tending to EOL (End-of-Life) bodies, aetiology of illness and caring practises for

older adults, I realised that sensitivity and reflexivity have to be the key ingredients in doing research along with translating the questions to the local context for the comprehensibility of the respondents, also looking into my comportment and tonality as a researcher. Analytic memos were gleaned out from the audio transcripts of the ayahs, family caregivers, older adults, interlocutors and key informants would be developed into analytic codes. The methodological paradigm from the work of Arthur Kleinman (1992), Julia Lawton (1998), Clare Stacey (2005), Julia Twigg (2000), Bra¨nnstro¨m and colleagues (2005), Anna Whitaker (2010), Marjorie Silverman (2013) and Sandvoll et al (2015) have been influenced my research design. Data was analysed through inductive-thematic analysis (Braun and Clarke, 2006) framework.

Paid Care for the Older People: Care Economy, Caring Landscapes and Domiciliary Care

Discussion on paid care for older people lies at the cross-roads of population ageing, transition in family system, care crisis and ensued alternative care arrangements. Interpretations, engagement and negotiation of the process of ageing is rooted in the broader cultural framework of local mores, organization of family and belief systems of the ageing population. Modern work culture characterized by work-life balance, deadline-based protocol and working round the clock makes potential primary caregivers in the family burnt out to provide full-fledged old-age care. The increase in market hours (or working hours) that may lead to a wage hike or when there is a greater preference for the market compared to home production, ensues a dent in informal caregiving. According to Hooyman and Kiyak (2008), the growing rate of divorce in the western countries of Global North is leaving the baby boomer generation of older parents to be taken care by their children. The underpinnings of care, stressors and rewards of care, and the role of care in intensifying intergenerational solidarity. Sarah Lamb's (2000, 2009 and 2014) work remains seminal to make sense of *seva* and the implications of intergenerational care in the Indian or the South Asian context.

Neo-liberal economy, globalisation and "performing family" can be identified as some of the factors in changing the landscape of care arrangement patterns and emergence of alternative care systems. Rajni Palriwala (2019, p. 250) observes that commercialisation of care and crisis of informal carers is rooted in the larger context of the unregulated globalised market economy that promotes work-life balance, competition to survive in a market that thrives on contract-based, part-time and flexible labour, and the regime of disciplined, commodified labour. The

range of illness for which the elderly patients seek palliative care nursing or end-of-care nursing in home are CHF (Chronic Heart Failure), Alzheimer's Disease (AD) Parkinson's Disease (PD) and Paralysis. Around 44.4 million people in the world are living with dementia that is expected to exponentially increase to 65.7 million in 2030. In USA, 22 per cent of the older adults in the category of 65 and above, and 42 per cent of the elders above 85 suffer from disability in the forms of visual, hearing, mobility, cognitive and communication impairment. Hooyman and Kiyak (2015) drawing from the study of Shanas (1979) argue that contrary to the social myth of adult children abdicating their caregiving responsibility towards their elderly parents by transferring it to institutional care, there has been a rise in adult children taking care of their elderly parents in the past 15 to 20 years. However, caregiving can turn out to be cumbersome and an extremely stressful experience for the carers (Pearlin et al, 1990).

Countries situated in the Global North have taken upon the task of remunerating and incentivizing caregivers to promote caring within the home-environment, and there is also an organized formal care system with care managers designing care delivery mechanism assessing the needs of the individual older clients. Feminization of caring extrapolates on synonymizing caring labour with women, and how this mindset, and locates women's out-of-home employment in the labour market for the emergence in old-age care crisis. Distribution of paid care among low-class, migrant women is reflective of the global chains that have ensued global inequalities through "dislocation of relations of direct care in institutions and the home." Availability of cheap caring labour of women located in the margins of caste-class-gender structural inequalities, the stigma of managing "dirt" of the human body in a caste society where norms of purity-pollution are deeply entrenched and the taboo of treating a "sick" person cluster them to this precarity. Women's entry into the occupation of paid care labour market lies at the crossroads of exploiting gendered performance/division of labour and the neo-liberal global economy of extracting cheap labour through further exacerbation of the existing structural and social inequalities. In her sharp observation of the growing care economy, Rajni Palriwala (2019, p. 249) argues that the "care economy mobilises the gendering of carework, social hierarchies and cultural practises to underwrite profit.

Presence of paid careworkers in home turns the home space into paid workspace and the invasion of medical equipment within home may turn it into quasi-nursing home. With the reimagining and reworking of the space of home as both family caregiver and paid caregiver towards care, the material space of home is reworked as it is enacted as a paid workplace. Atiya Mahmood and Anne Martin-Matthews (2010, p. 23) state that the ordering of home and the

meanings imbued to it alters as it turns into a setting for long-term care. Introduction of care into the homespace changes the interpersonal relations within the household and so as their daily routines. Chronic illness or any kind of assistive care disrupts the space of home as "private territory" and "family". Home care enables caregiving practise from the public sector to shift to the private residential space.

The onset of covid-19 pandemic has disrupted the business of the ayah centers and many ayah centres were shut down as informed by Kalpana who has been working as an ayah in Bhoumik Household for the past 12 years. It has also led to the low-bargaining power of the ayahs who now are further pushed to provide service with low wage. However, another side of the situation that surfaced through Parboti's (associated with ayah care service for the last 3 years, and has the experience of catering to largely "showa patients" or "highly dependent patients) narrative is that the centre in which she worked charged double the rate from the "patient party" (patient's family is locally referred as "patient party" in the nursing/ayah sub-culture) and the ayah also had to pay double the daily commission. In her case, if earlier she had to pay 30 INR per day, now she had to pay 60 INR per day to the ayah center. Sujata who has been associated with ayah-care service for 17 years and have worked solely through ayah centres is of the view that the high or low-rate paid to the ayahs working in the ayah care centres is determined by the variable of condition of the patient, i.e., whether the patient is highly dependent (showa/hanta- if it is a showa patient the rate would be higher) or the distance (*durotyo* that is within different districts in the state). Dolon, an ayah with 27 years of care service states that the rate of attending to a "showa patient" is higher compared to average rate in her centre as the labour required in hoisting the patient and entailing in "double-handed care" is more. Ayahs with prior training in nursing may get to handle patients with complications and consequently there is a possibility of earning higher wage. However, she laments that despite nursing training the ayahs may not be in a position to bargain more for their service and end up being underpaid- "*eto kom rate-e kaaj koraye nursing training thhaka shotteo*". Ayah care service can be for 6 hours, 8 hours, 10 hours, 12 hours or 24 hours depending on the requirement of the "patient party" as reported by the ayahs. In case an ayah is recruited for providing caring service in another state, her remuneration also goes up higher. Daily wage paid to an ayah is done so after every 10 days. Earlier the interval was of 15 days.

Predicaments about letting ayahs enter the threshold, living in the age of precarity and older persons being "at risk group" played into ayahs either losing jobs or their regular service being turned to stay-in service. My interactions with an ayah centre revealed that many ayahs have lost their job as their demand has decreased. Some of the reasons cited for this are (a) the routine entry and exit of ayah from the home of older patient is not acceptable by many families as it may jeopardise their and the patient's health (b) the care deficit that emerged due to the professional workload of the family caregivers can now be performed by the family caregivers because of the transformation in working condition---work-from-home (c) the push and pull factor of 'normal' and 'new normal' society. The phenomenon of ayah culture stokes the question of caring landscapes, ethico-morality of caring, and caring for a decaying body as an aperture of reflecting on intergenerational and interpersonal ties. This also makes me ruminate about care capital-Those who can purchase care or have access to care and those who are left to fend for themselves and undergirds on the possibilities of existing asymmetries in the delivery and receiving of care.

Ageing Body as a Site of Solicitude: "Intimate Labour" and "Dirty" Dying

Caregiving to an older person is characterized by intimate labour. Human beings are embodied and their everyday life is dominated by the details of corporeal existence (Low, 2017). Bodywork is labour provided on the bodies of others that includes bodies that are conscious, live, intact, work on body parts and bodily excretions (Cohen, 2011, p. 21-22). Julia Twigg et al (2011, p. 172), argue that bodywork entails hands-on activities, assessing, handling and manipulating bodies. Bodywork is ambivalent as it involves labour that encompasses the terrains of pleasure, eroticism or emotional support. Twigg (2000, p. 395) argues that caregivers deal with the aspect of handling body waste in a culture that is sensitized to the transgressions or the bodily failures. Another dimension is dealing with the nakedness of the aged bodies. Thirdly, given the meanings accorded to the human body, touching the body evokes ambivalent emotions for the caregivers. Much like home that is emblematic of "privacy" and "secrecy" so as the human body. Body and its different zones are imbued with different connotations and underpinnings. There are norms, prescriptions and proscriptions related to the human body. In certain cultures, touching someone from the opposite sex is deemed as taboo, in some cultures touching someone without their permission may be

construed as harassment, and in some cultures during social exchanges touching may be allowed in certain parts of the body and touching certain zones of the body may be deemed as inappropriate. The private nature of the body construes it as sacred and it ensues in construction of bodily integrity as pious, and invasion of those spaces as profane. Body carework concerns with maintaining orderliness of human body through keeping it clean, presentable and 'lounge standard' patient as found by Geraldine Lee-Treweek (1997). I would argue, that this disciplining of the body against the threat of uncleanliness and incontinence constitute an important element of the ayah's work profile.

Ayahs have to manage bodily disintegration, incontinence, negotiate with the blurring boundaries of intimacy through synonymising the patient as a parent or through infantilization of the patient. They control their repulsion or *ghenna* of bodily disgust through normalization of disgust and with the realisation that their ability to remain unmoved is the key to retaining their job. Their acceptance of the dirty aspect of their occupation stems from the structural inequalities that have imprisoned their social and occupational mobility. Incontinence is a condition when a person is unable to control defecation or urination. Attending to a highly dependent patient who can be termed as a *"showa patient"* connotes that the patient is completely reliant on the ayah for their everyday, banal activities including assistance with discharging bodily wastes.

For "ekdum showa" patient or the highly dependent patient we make them wear adult diapers because during the time for defecation, the patient would neither be able to call or tell; that would be worn by the patient throughout the night and in the morning, it would be cleaned and the one who stays in the day would not make the patient wear it. (Parboti)

Ayahs are expected to perform a range of intimate and "dirty" labour. A detailed list of intimate labour performed by the ayahs include shaving the beard and underarms, cleaning the excretory regions post body waste discharge, massaging the patients to promote blood circulation and ameliorating pain in the limbs, measuring the urine discharge of the patient so as to balance the drinking water intake, changing adult diapers, cleaning the mucus of patients, bathing a patient and drying the body of the patient after bath, brushing teeth and washing mouth. *Kobita associated with ayah service for 5 years, and with an experience of working through ayah service centres as well as direct entry (through ayah cohort), stated that she had to massage kalo jeera oil (nigella seed oil) to one of her clients. Madhuri, an ayah who has been doing ayah care service for 1 year said that her tasks include accompanying the patient to the bathroom, bathing the patient, bathing him, feeding him, giving support as he walks, applying*

oil to his feet and since he has catheter so helping him with that. All these demands from the ayah that she will have to directly touch the patient or be in close in contact with the patient. This further indicates that the ayah becomes familiar with the unique or distinctive smell of the patient, aware about the marks, deformities and features of the patient's body, and the postures and corporeality of the patient. The blurring boundaries of intimate labour posits issues of sexual harassment as insinuated by some ayahs.

As recounted by Tapashi while massaging the body parts of the male older patients one needs to maintain caution and interpret their intentions from their body language. During massaging the patient sometimes male patients would want us in close proximity; "byata chhele patient khub sabdhhane thhakte hoye, kothha shunei, shore porte hobe, kachhe thhaklei khharap hoye jabe." She went onto state that although this is an occupational hazard for the ayahs, however for these male patients, this maybe an influence of strong drugs or effects of illness or lack of physical intimacy in old-age (3:30).

I have tried to locate this discomfort and disgust towards dirt through the work of Mary Douglas (1966) who argue that hygiene standards followed in the everyday life are akin to the dichotomies drawn between purity and pollution. In the final section "distributing labour", I am trying to explore whether retaining "intimate" labour to the family caregiver or outsourcing an ayah for the same evinces the degree of proximity or determines the dyadic dynamic between the patient and the family caregiver.

Maladies, Affliction, and Bodies in Pain: Illness Narratives and Care Practises

Illness of an older person at home shifts and recalibrates the lives of people around them (Bury, 2001, p. 277). Although defined by its onset, aetiology, pathognomonic symptoms and course of medication rooted in the medical sciences, the management and personalization of care of the older patient are sociologically embedded. Kathy Charmaz (2002, p. 282) is of the view that the current spate of narrative research and the growing interest in illness narratives is to obviate the "dehumanising effects of a medicalised society, and the effects of forms of medical practice that deliver increasing technical sophistication but fail to offer comfort and care for patients as whole human beings". Mapping and construction of illness narratives can influence the ways we associate with the representations of the pangs of the patients or travails of the caregivers.

Illness narratives culled from the respondents indicate the ways in which the "self" of the patients is reconfigured through bodily deterioration. In this regard, the phenomenological discourse is relevant to make sense of the 'lived body', the body becoming a vehicle in perceiving the world and shaping the selfhood of the patient. In Lawton's (2003, p. 87) verbatim, "Understanding embodiment as the experience of both being a body, and living through a body, thus provides an important conceptual perspective of understanding why a patient's self is affected when various bodily capacities and capabilities are lost." Her ethnographic fieldwork foregrounds that incontinence, locomotive impairments and bodily deteriorations ensue in loss of self of the patients. As the dependency and bodily decline of the patients increased, their perception of the 'self' shifted from the subject to that of the object (Williams, 2003). The aspects of the human body that becomes conspicuously visible during dysfunctions can have a debasing effect of the 'self' of the patient. Inability of the patients to move and hence becoming dependent on caregivers for assistive care makes them feel like an "object".

Sufferings, resistance and difficult behaviour

Afflictions due to illness and its repercussions leads to sufferings. Suffering encompasses both existential signifier of human conditions and a form of practical world (Wilkinson and Kleinman, 2016). Defiance of the instructions of the ayahs or the family caregivers is resistance of the older adults to "deny old-age" and precarities that accompanies biological ageing. From the perspective of the ayahs a non-compliant patient makes their tasks difficult, however from the perspective of the patient non-compliance is resistance against medicalization, pathologization and infantilization through medical supervision and administration of medicines. Difficult behaviour from patients may also be traced to their resistance towards an "outsider", "bairer lok" "bairer mashi" a woman located in the social periphery trying to discipline him through delivery of care. This insinuates the hierarchical power relations between the patient and the paid caregiver, Resistance can be interpreted as an onslaught on manhood, selfhood, class-caste hierarchy and old-age based superiority of the patient

Ayahs distinguish between a *kharap* patient and a difficult patient. A *kharap* patient is one who is in end-of-life care or have to endure bodily pain like a patient with malignant cancer or advanced stage cancer. On the contrary, a difficult patient is one who troubles the ayah and impedes her care arrangement. Paralysis patients or older persons with CVA require double-

handed care, in the ayah sub-culture known as *"chagano patients"*. Ayahs have to massage the legs of older persons with paralysis to promote blood circulation, and assist them in turning from one side to the other, make them sit while feeding or brushing their teeth. Showa patients are made to wear adult diapers for those with incontinence especially during the night time as caregivers (both family caregiver and ayahs) avoid taking them to the bathroom at night. Inability to move at one's will and perpetual dependency on the ayah has certain implications. The patient experiences an onslaught on the self, haunted by somatic decline and confinement that makes them feel suffocated. All these feelings make them succumb to silence or they remain irritated all the time.

Drawing from the study of Marjorie Silverman (2013) who talks about the experiences of women caring for their spouses and developing a caregiver habitus, I argue that the ayahs through their lived experience of caring and their situated knowledge develops an ayah habitus that embodies the ayah sub-culture. For women, caregiving for others is socially imprinted and part of their gendered conditioning, hence their suitability for the tasks is taken-for-granted. Ayahs by virtue of their caregiving tasks, care practises and care performance develop a vocabulary, emotional make-up and embodied experience exclusive to the lifeworld of ayahs. The ability of an ayah to identify symptoms of dying, strategizing measures to resuscitate an end-of-life patient, techniques of symptom management and informing family caregivers about the death of the patient constitutes her ayah habitus. There may be a difficulty in informing about death as it means dousing off hope and hurting the closed one as the temptation to the protect the person is ceased (Aries, 1981). The language used by the ayahs to typify and categorize patients in various stages of illness and demarcate their degrees are modalities through which ayahs comprehend and make sense of human sufferings. Linking excruciating pain of older persons with mistakes they might have committed in their lifecourse becomes a self-reflexive exercise for the ayahs to evaluate their personal actions to not meet similar fate. This notion of associating pain with mistakes has been termed as "divine misfortune" or "divine punishment" (Helman, 2007). While ayahs feel irritated with a patient who does *"bokbok"* or talks too much, they are perspicacious to understand that the effects of illness, sufferings and loneliness on self of individuals. Confronting the ramifications and vagaries of ageing and dying on an everyday level is stressful for the ayahs. There is a distinction between caregiver burden that refers to the tasks performed by the caregivers and caregiver stress that refers to the pressure felt by the caregiver. Caregiving ensues adverse effects like exhaustion, fatigue, fluctuating blood pressure level and damage of well-being (Quadagno, 2018, p. 281). This in

turn is imprinted in the bodily dispositions of the ayahs especially with the symptom management and emotional labour to a dying patient. With the demise of a patient, the ayah finds it difficult to process the loss despite the awareness about death. Ayahs may take leave from paid carework however unpaid carework in their home continues. This provokes the question whether ayahs ever get adequate time to recover from the death of their patients? This emotional toll has been a reason for some ayahs contemplating of leaving ayah care service and looking for alternative livelihood opportunity. Dasgupta and Charon (2004) advocate for reflexive clinical practise that would allow the medical practitioners to combine personal reflection of illness with clinical practise with a view to develop empathy in tandem to the biography or the lifecourse of the patient's sufferings. Ayahs in reciprocating care to the patients and devising practises for the patients draw from their lived experience or situated knowledge as opposed to any clinical education. In this way, ayahs are different from the professional nurses as ayahs. However, this lack of training work against the ayahs as they may lose out on attending to critical care patients and the possibility of higher income in taking care of such patients. While illness narratives have focused on patient-centred narratives, a radical departure from the top-down, biomedical knowledge emerging from the "trained experts", the possibility of ayah-centred illness narratives and tandem care practises have been underexplored and undertheorized. This knowledge of the ayahs in taking care of older patients and identifying the distinguish features from attending to children, I would argue is "knowledge from below". Bela who is new to ayah care service and was recruited by a family through cohort of paid domestic help, shares her care practises that emanates from her personal understanding of the patient, reflex and familiarity with the quirks of the patient. Ayahs have to deal with patients who resist the change happening to their body and this process of submitting to someone is reflected through resistance. Even in states of marginality of health, older people show resistance through refusal to consume medicine and the disciplining of their self by the ayahs. The sight and embodied experience of gradual decay of the body may trigger defiance, exasperation, bad temper, silence or reticence (withdrawal) as a response to the precarity of old-age. Patients can turn violent and abusive, and ayahs have to demonstrate control of the self while dealing with such patients. This competing self of the patient who denies and resist through being "difficult" and the ayah whose "self" has to be patient and composed is what I would argue as the competing selves in micro-unit of everyday home-care that makes care in its most banal state achievable and continuable.

Configuration of Care and Mapping Intimacy: Familial and Non-Familial Boundaries

Home and caregivers: Ghore-baire

As "strangers", "outsiders", "bairer lok" enters the home, the propensity to draw boundaries that segment activities, spatial ordering and legitimacy of the "insider" and the "outsider" deepen. Within the home, while an ayah controls and supervises the body of the patient through the disciplining acts enmeshed in care, the ayahs in turn are controlled by the family members through perpetual surveillance and expectations discreetly laid out at the outset of the recruitment or the induction process. This ensures that segmentation is being maintained, boundaries are being protected, and rules and values of the 'sansaar' is being followed. As evocatively stated by Tapashi, *"byabohar, nijer jaegata toiri na korle, porer ta kora jae na, tai jonyo bole na jar bari duty korbo, se amar apon, abar nijer bari'r hole ashle se amar apon"* (One has to make one's place in the patient family through her demeanour and conduct so that there is reciprocity, that is why it is said that one has to treat the patient's family as one's own and also do the same with one's kin). She referred to the "home of the patient" as well as her home as "sansaar" underscoring the essentiality of developing propinquity with the patient and the family, treating the patient's home as one would do with one's sansaar.

Reciprocity, well-being and 'nijer moto'

Fortes and other anthropologists contend that kin relationships are embedded in the feelings of duty and moral claims, and are characterized by obligations to provide assistance and share resources in times of crisis. I found that such obligations and reciprocal exchange are not limited to the kin networks but also the ayahs as they feel the essence of their service demands commitment and reciprocity akin to intergenerational expectations within a family. As caring for an elderly patient is construed as "duty" that is termed in the ayah subculture as "patient-er duty", this duty accompanies a sense of "responsibility" as it is aimed toward well-being and positive ageing experience of an ailing person. This consciousness intensifies as the ayah starts relating to the patient and her family as her own, part of her 'sansaar', the attachment to the domesticity of the patient evokes her gendered cultural socialized as a woman whose primary responsibility is the 'home', the 'private'. Here although the private is also her workplace, an economic category yet this 'private' is imbued with sociological meaning, home for the patient's family, workplace for the ayah that she is also expected to treat as her home so that it

is expressed in the nature of her care performance or caring labour. This commitment towards the patient stems from the filiality experienced from the patient and the family members.

Food, levelling and gradation, and we-feeling

Food as a subject has emerged recurrently to indicate proximity, distance and ambivalence with the family an ayah is associated. Filiality is practised and intimacy is expressed through food-whether it is mashing the food in a specific way for the patient or sharing food with the caregiver as a gesture of solidarity. Ayahs have stated that they feel integrated with families that provide them with food. Integration with the family occurs through the ability to make choice, freedom to subvert the spatial ordering and not making segregation in food eaten by the family and the ayahs. In many of the cases it was observed that for the ayahs "being like a family" or "feeling home" insinuates on the autonomy in decision-making, having the liberty to take food from the kitchen and refrigerator without having to seek permission, food has been found to be a tool for the solidification of bond and strengthening intimacy. The insider-outsider and familial-non-familial dichotomies are sharpened around the subject of food. For them it also marks a levelling of the existing structural hierarchy and neutralize the asymmetrical relations through the shared consumption of food. This has bearing on whether they feel integrated with the family they are working for or do they alienated, dissociated and distanced. For the ayahs, this also has implications whether they will contribute labour beyond the verbal contract with the patient party and the centre/ayah.

"Barir moto hoye gechhe. Amra nijer haath-e khayi, amader keu kichhu bolena, onyano barite jerom meyeder bole, eta khabe na, ota khabe na, serom ekhane kore na, or ja khhaye, amio tai khhai, kaaj er lok bole ora amaye e kore na, amra nijer moton khai, nijer moton thhaki, nijer moton jamakapor e kori. Ei jonyo onyo bari gele poshaye na".

Sansaar, familiality, kinning and blurred boundaries

Filiality emerges from familiarity of micro-exchanges of reciprocity experienced by the ayahs that they feel cannot be experienced anywhere else. This exclusivity of reciprocal exchange anchors the ayah to a certain family and translates to being part of the family in a "home-like" setting, and being integrated with the 'sansaar'. This right over a 'sansaar' where the ayah gets

to make decision, have access to good-quality food and through her affectivity participate 'intimate' labour everyday solidifies the bond between the ayah-patient, and ayah-family of the patient. On the other hand, the patient too, despite her tantrums, resistance and at times discontentment with the ayah gets used to the patient, it cannot be referred as filiality in all the cases but familiarity. By familiarity I mean becoming familiar to the specificity of caring practise of the ayah, the peculiarity in which the ayah finds strategies to make the patient concede, the disciplining mechanisms of the ayah and tactility/corporeality of the ayah whether the tonality of her voice, her demeanour or the comfort that she derives in moments of companionship. The patient being vulnerable with the ayah, breaking down into paroxysm due to illness related afflictions, fractured filial ties or the yearning for death yet again underlines the proximity. This proximity that develops between an older patient located at the periphery of health and the ayah located at the margins of poverty, caste, culture, gender and space may create a shared podium of coming together, of empathy and intensifying their ties. Marginality and exclusion in both the cases, although distinct inaugurates a possibility for solidarity and 'we-feeling'.

Trust and Faith

Trust and faith in the loyalty of the ayah towards the family, and well-being of the patient is a factor that does not appear much in the existing literature. Trust is a two-way process. The family caregiver and patients trusting the (a) intention, (b) ability and (c) attributes of the ayah. Trusting the intention of the ayah translates to trusting her with the house, money and material possessions that are valuable to the patient and the family. Trusting the ability of the ayah refers to the experience, skills and expertise that translates to the 'repeat value' of the ayah, recommending the ayah and knowing that the ayah is best at her job with the patient. Trusting the attribute of the ayah refers to her demonstrable qualities and personality traits that makes her a good companion, an ideal healer and in line with the family of the patient. It is also the personal attributes of an ayah that makes a patient or a family caregiver confide in her with information related to intergenerational conflict, gossip and family secrets. Sharing sensitive and intimate information underscore the exclusivity and the "sacred"-ness of such information, and sharing, and exchange of views on the same becomes a marker of filiality. All these three factors contribute in making the patient's feel like integrated, embedded with the family, and translates in filiality with the patient and the family.

Conclusion and Afterthoughts

The trend of outsourcing care labour to ayahs with manage home-care indicates at the medicalization of ageing, technologization of home-care, commodification of bodies, commercialization of intimacy and eventual bureaucratization of micro-sites of care. Beyond the binary of filiality and non-filiality, relationships are ambiguous, there are crests (high-points) and troughs (low-points) and the moments of competing interests are negotiated through the meanings derived by each of the stakeholder based on their situated experience. There lies converging and competing interest between the ayah and the family caregiver. While dealing with the "difficult" behaviour from patients, compassionate behaviour from the family caregivers ensures the ayah that her efforts and ordeals are recognized. This recognition and reinstating the value of the ayah, her wounded esteem by the family caregiver undergirds the long-term tie between the ayah and the family of the patient, and ensuring long-term care of the older person. Considering the objective of the family caregiver is to retain the service of the ayah, the language and gestures are to be interpreted along the lines of how solicitude is managed at the micro-level. Both the parties are evaluating/weighing rewards and penalties in the arrangement and management of care. This leads to the argument that these notions of filiality, familiality and other is not embedded across time and space rather shifting and fluid much like relationships in late modernity as envisaged by Zygmunt Bauman (2013) in his path-breaking work on Liquid Love. For ayahs to make sense of the "intimate labour", emotional demands and "repulsive aspects of bodily discharges of patients" associating their work as seva having a transcendental quality and derive fulfilment. While this is a key for ayahs to negotiate their labour, make sense of their everyday caregiving experience and survive the occupation, there lies consciousness in the ayahs that failure to do so will lead in the loss of job and switch to relatively underpaid cooking and domestic chore tasks. In essence, the components of "duty" (translates to sense of responsibility), "exigency" (emergency of dealing with bodies to be continuously supervised), "reciprocity" (showing affection and concern bordering on filiality and familial belongingness) and "well-being" (alleviation and transition to a better condition) that separates ayah care service from allied occupations of paid cooking and paid domestic chores. The onerous nature of the occupation and the "responsibility" of promoting well-being of an older person has made many ayahs feel that caring for a child is easier to that of a "patient", especially the ones with cognitive impairment who can turn out be obdurate and challenge the notion of a docile body, and for them a patient is synonymous to an older adult. This is the paradox of caring labour for an older person.